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Jacqueline C. Gahagan  
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WOMEN AND AIDS: THE SOCIAL CONSTRUCTION OF FEMALE SEXUALITY  
AND THE BARRIERS TO HIV PREVENTIVE BEHAVIOURS

by

Jacqueline C. Gahagan

Submitted to the Faculty of Graduate Studies and Research  
Through the Department of Sociology & Anthropology  
in Partial Fulfilment  
of the Requirements for the Degree of  
Master of Arts  
at The University of Windsor

Windsor, Ontario, Canada

1995

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## ABSTRACT

### WOMEN AND AIDS: THE SOCIAL CONSTRUCTION OF FEMALE SEXUALITY AND THE BARRIERS TO HIV PREVENTIVE BEHAVIOURS

An examination of the social construction of female sexuality is used to gain insights into the gap between AIDS knowledge and safer sex behaviours. The analysis of data brought forth by 20 open-ended interviews with young women at The University of Windsor is used to assist in understanding the barriers faced by these individuals as they attempt to negotiate safer sex. The emphasis of this research has been placed on the interviews as a method of going beyond quantitative data in attempting to recognize how young women make sense of their sexual experiences and the social context within which they occur.

Current AIDS education messages may not be sufficient to alter young women's behaviours because these messages alone do not address the inherent contradictions between 'being female' and exerting control in terms of sexual safety and sexual negotiation. Recommendations for AIDS education programs which are both gender specific and sensitive to sexual orientation are discussed, as well as the need for a shift in sexual paradigms which reflect women's construction of their own sexualities.

## Acknowledgements

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I would also like to express my gratitude to those young women who were willing to fill out the questionnaire and to those who spoke with me so candidly in the interview. This research would not have been possible if not for their bravery and interest in coming forth to share their experiences.

## Dedication

This thesis and all that it represents is dedicated to two women whose influence has both enriched my life and driven me to carry on despite the odds: Grandmother Helena Augusta Victoria Potter Carson Craig, and to the memory of my mother Dorothea Isobel Gahagan.



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## Chapter 1

### Introduction

As the AIDS epidemic continues to spread among sexually active women, attention has begun to be placed on risk behaviours for HIV transmission (e.g., sharing of needles, unprotected sex) as opposed to a continuing reliance on the 'risk group' paradigm (i.e., IDUs, gay men). Only recently have we seen research on Acquired Immune Deficiency Syndrome, or AIDS, slowly begin to shift away from a disease of marginalized groups to become a medical concern to a broader segment of society (Patton, 1994).

After more than ten years of AIDS research, medical authorities are slowly beginning to recognize that many previously 'immune' groups in society are also at risk for contracting HIV, the virus believed to cause AIDS (Shayne and Kaplan, 1991). Due, in part, to the realization that the mechanics of HIV transmission remain the same regardless of the host body, there has been a slow but steady overturning of previously held beliefs, both medically and socially, concerning who is at risk for HIV.

This slow progression away from the risk group paradigm to those HIV risk behaviours previously not targeted by AIDS education and awareness campaigns has had devastating consequences. These consequences have been particularly devastating for sexually active young adults. It is now

becoming widely accepted that so-called conventional heterosexual sex without the use of a latex barrier has put sexually active teenagers and young adults at risk for HIV infection (Patton, 1994). According to Karen Hein (1991), director of the Adolescent AIDS Program in New York, HIV and AIDS pose a very significant threat to the teenage and young adult populations, and yet HIV research, prevention and service programs fail to address their unique needs.

Not surprisingly, the absence of specific types of sexual risk behaviours from the HIV/AIDS awareness discourse of the 80's has resulted in many sexually active young Canadians becoming diagnosed with HIV in the 90's. Given the lengthy asymptomatic period of HIV infection, it is quite conceivable that these young people became infected while in their early teens and were not diagnosed until they were well into their twenties. The (mis)information put forth by many health education organizations in the early 80's was largely based on the notion that AIDS was a disease of homosexual men, injection drug users and prostitutes. The linkages between actual risk behaviours and so-called risk group membership were often overlooked in favour of the now disputed risk group paradigm (Campbell, 1990).

When we consider how HIV can enter the bloodstream we quickly realize that it is virtually the same for all people regardless of sexual orientation, colour, social class or gender. According to the Safer Sex Guidelines produced by

The Canadian AIDS Society (1994), the routes of HIV transmission have been well established. These routes consist of specific types of sexual behaviours, the sharing of used needles, mother-to-child transmission (in utero, during childbirth or through breast feeding), and receiving infected blood or blood products, transplanted organs, or through artificial insemination.

Given the range of behaviours which may facilitate HIV transmission and infection, HIV/AIDS has begun to be a concern for previously unaffected segments of the population. And although there are only a number of specific ways HIV can be transmitted sexually, one main route, and the focus of this research, is for HIV to enter the bloodstream through sexual behaviours with an infected partner without the use of a latex barrier. Upon entering the bloodstream, HIV (Human Immunodeficiency Virus) damages and slowly destroys the immune system, leaving the infected individual susceptible to a variety of infections which a healthy immune system is able to fend off (Canadian AIDS Society, 1994).

The mechanics of HIV transmission are clear, whereas the fact that one may be HIV positive and not even be aware of it carries with it another set of less clear issues. One such issue lies in the fact that it is possible for an individual who is infected with the virus to pass it on to their sexual partners without realizing they have done so.

And, although the newly infected individual may remain asymptomatic for a long period of time, they are still infectious and could unknowingly transmit the virus to others during, for example, unprotected sexual intercourse.

With this in mind, some AIDS education messages have suggested that sexually active young people should use a latex barrier (a condom or dental dam) when having sex. It has also been suggested that, to be completely safe, these young people should abstain from sexual behaviours which can put them at risk for HIV, such as unprotected penetrative intercourse, and to refrain from sex with people whose sexual history they do not know. However, given the fact that fifteen-year-olds are five times more likely to be sexually active today than their counterparts were a generation ago, these messages of abstinence may be futile (Doherty et al., 1993).

According to the Canada Youth and AIDS Study (1989), 31% of male and 21% of female grade nine students had had sexual intercourse at least once. By grade 11, nearly half of both the male (49%) and female (46%) respondents reported having had sexual intercourse. Because many young adults are engaging in sexual intercourse, with or without adequate protection, they are a population at risk for HIV and AIDS and in need of further research (King et al., 1988).

The issue for many young people is not one of more AIDS education but rather making these messages relevant to their

lived experiences as they begin to discover their sexuality. This is particularly problematic for young women who, while aware of the potential risks associated with unprotected intercourse, are often more concerned with avoiding pregnancy than with STD prevention (Moore and Rosenthal, 1992). Thus, the connection between HIV/AIDS and female sexuality still remains largely uncharted territory.

The fact that we are now only beginning to see literature and research which address the issue of women and HIV/AIDS preventive behaviours is indicative of the long history of ignoring the utility of safer sex messages tailored to young women. Not only must these messages be specific to the target audience, they must also be expressed in ways which are meaningful to these young women. The lack of useful information geared to young women about HIV/AIDS avoidance behaviours is simply another demonstration of the invisibility of female sexuality (Holland et al., 1993).

The purpose of this research is, therefore, to explore the sexuality of a group of 20 young women as they construct, interpret and negotiate their lived experiences with sex. This exploration will include the complex and multifaceted issues associated with adherence to safer sex guidelines and the avoidance of HIV transmission. Of particular interest is how such sexual behaviours and interactions are socially constructed and understood. This research will investigate female sexuality from a social

constructionist perspective in an effort to address the gap between the safer sex messages and actual behaviours.

Central to this research is the realization that there exists an imbalance in relative power of men and women in our society, and as a result an imbalance in sexual relationships. This may be particularly evident for women when it comes to the negotiating of sexual practices, including safer sex or non-penetrative forms of sexual expression with their male partners (Holland et al., 1994). The complexities of how sexuality is constructed, regulated, and (mis)understood between partners is equally significant for heterosexual women and lesbians. From this we can derive the supposition that the degree to which young women incorporate safer sex into their sexual repertoire is a reflection of the level of comfort experienced, and the degree of control expressed in their sexual encounters. The ability to negotiate safer sex, and more pleasurable sex, may differ from individual to individual and from context to context. This variability is, in part, determined by how the individual's sexual reality is constructed and rendered meaningful for them in their interactions with others.

Responses from open-ended interviews will be examined in order to reveal issues associated with AIDS and sexuality such as sexual autonomy (or the degree to which a young woman feels in control of her sexual expression), how the individual attempts to negotiate safer sex, and how her

sexuality is constructed and understood. The interviews themselves are paramount to gaining insight into the social construction of female sexuality and the development of gender appropriate HIV preventive strategies. The focus of this research will therefore remain on the richness of the information garnered from the interview results.

The importance of research on female sexuality, social construction theory and HIV/AIDS will be addressed in the following chapter. Chapter Three will outline the methodology used in this research. Chapter Four presents the results from the interviews, and Chapter Five will provide a discussion and concluding remarks on the outcomes of the research project.



## Chapter 2

### Literature Review

Many representations of women and AIDS have focused on women and the caregiver role, or women as relatives of HIV positive men. One significant exception to this representation is the depiction of the female prostitute as a 'vector of transmission' to unwitting men and their families. The popular media illustrate how women and AIDS still do not fit together, but this alone is insufficient to explicate why women's sexuality remains largely outside the AIDS research and literature of the 1990's (Juhasz, 1993).

However slowly, social research is beginning to take women and AIDS out of the shadows (Holland et al., 1994). This move is not only a direct result of the increasing numbers of women diagnosed as HIV positive, but also in response to our as yet unanswered questions concerning why women have remained invisible in the dialogue of HIV/AIDS for so long. "Despite the growing incidence of AIDS and HIV-positivity in women, the situation of men with AIDS is usually taken to be the norm, and the issues that concern women - particularly with respect to reproduction and sexuality - are regarded as specialized, marginalized, and less significant...the assumptions that women's illnesses - and indeed, women themselves - are less important than men" (Overall, et al., 1991, p. 28).

This issue becomes more apparent when one compares the amount of research conducted on women and HIV transmission to the thorough investigations of male sexuality and diseases such as HIV/AIDS. As Cindy Patton (1990, p.14) points out "questions are routinely asked of men - including number and gender of partners, exact sexual activities with partners, and discrepancies between sexual identity, orientation and behaviour - have not been asked of women". The fact that AIDS was endemic among many groups of men gave credence to allocating resources in a variety of fields to study the routes of transmission. The results for women have been to underestimate the likelihood of heterosexual transmission of HIV and to concentrate resources sparingly on risk factors for women who are sexual partners of injection drug users or bisexual men. Women's risk becomes defined largely by their sexual relationships with men or their "reproductive imperative" and not based on their own sexual desires (Holland, et al., 1994).

This lack of research on female sexuality and the possible connections with HIV infection from a variety of sources has produced an arm's length evaluation of individual risk for most women. Many heterosexual women were told by the 'experts' that they are not regarded as an 'at risk' population, although the mechanics of transmission are much the same for so-called at risk populations and those deemed 'safe'.

The topic of women and HIV/AIDS has not been the focus of many comprehensive research efforts since the beginning of the epidemic (Patton, 1994). This is backed up in large measure by the fact that the association often made in the media and other social signposts with respect to AIDS is still largely directed toward so-called 'at risk' populations such as gay men, IV drug users and prostitutes. For those who do not fall within one or more of these risk categories, their sexual behaviours are not regarded as putting them (or their partners) at risk for HIV (Squire, 1993). However, as more young heterosexual women in Canada become seropositive, we must move away from the risk group paradigm and begin to understand the issues faced by many young females who, unlike gay men, are often unfamiliar with the psychosocial barriers and power differentials involved in negotiating more pleasurable and 'safer' sex (Patton, 1994).

To better understand the barriers faced by this population as they attempt to make sense of safer sex messages, we must look at how female sexuality is shaped and made real for these young women. In an effort to do so, we must regard female sexuality as a social construct consisting of a variety of sexual scripts and norms, which not only creates meaning, but is also a relatively rigid set of parameters within which young women must negotiate and make sense of safer sex messages.

Young women are at risk of becoming HIV positive through sexual behaviours for a variety of reasons, not the least of which is the inability of many young women to successfully negotiate safer sexual encounters with a partner. This becomes particularly problematic for young women who have been socialized to leave their sexual safety in the hands of their partners (Haug, 1987). As a result, these women may find that the safer sex messages they are given are in direct conflict with their lived experiences and often find it impossible to incorporate such messages into their sexual encounters.

From the outset, Acquired Immune Deficiency Syndrome (AIDS) has not been viewed as a central health concern for women largely due to the fact that AIDS has been depicted as a disease affecting primarily, if not exclusively, the white gay male population. This in turn has caused 'women' as a collectivity to be systematically overlooked when it comes to research and recommendations for AIDS prevention programs. As Cindy Patton (1990,p.29) suggests, "the paradigmatic representation/embodiment of the 'AIDS virus' is the gay man". However, more recent evidence suggests that AIDS is in fact a significant health issue for women, not only because the number of women who are being diagnosed as HIV positive is increasing at an alarming rate, but also because a great many women are sexual partners or primary care givers of those with AIDS (Squire, 1993).

The health issues concerning HIV/AIDS are complex and multifaceted, as are the politics of establishing a discourse on women and sexuality in the face of AIDS. As the numbers of those who are HIV positive increase, so too are the number of AIDS organizations on the rise, and all are vying for the public's attention (Overall, 1991). The end result reveals a politically charged and often times skewed message of control within the highly contested realm of sexuality. In the midst of this political hotbed are the women who, when attempting to incorporate the latest safer sex messages into their lived experience, are often found struggling in the contradictory abyss between message and practice.

The politics of sexual control vis a vis our messages regarding AIDS has had a particularly devastating result for women in attempting to incorporate issues of sexual safety into the reality of everyday life. The way we perceive our sexual world is to a large degree a reflection of the messages our society sends us. As Dorothy Smith (1987, p.17) posits, "The relations of ruling in our kind of society are mediated by texts, by words, numbers, and images on paper, in computers, or on TV and movie screens". Accordingly, it is these 'texts' which wield the power to shape, motivate, and control our reality. The reality espoused by the mass media coverage of AIDS has tended to sensationalize the 'novel victims' (Magic Johnson) or

'innocent victims' (HIV+ new born babies) of the pandemic.

This reality manifests itself in our belief in a fabricated division or duality of 'good' versus 'evil' AIDS 'victims'. (The latter is often referred to as an 'AIDS carrier'). The reinforcing of this stereotype with respect to women may serve no other purpose than to reaffirm the notion that 'good girls', (presumably those who don't use injection drugs, who are not prostitutes and who don't sleep around) don't deserve to get a disease like AIDS. Rather than delineating between those who deserve the disease and those who don't, it may prove more productive to develop a critique of female and male sexual socialization as it impacts on HIV preventive strategies. Many of the attitudes we hold with respect to who we think may be at risk for contracting HIV may result in our underestimating our own perceived risk for HIV infection. Such attitudinal manifestations often become evident not only in the semantic differential used to describe one reality from another, but in the subsequent action (or inaction) toward HIV infection or the infected individual(s) themselves (Patton, 1990).

It is this media distortion (both socially and politically) and the general societal need to lay blame which has resulted in the needs of women living with HIV/AIDS, as well as the women who are attempting to remain seronegative, being overlooked. The need to focus research on women and HIV/AIDS has resulted from what has been

referred to as the medical establishment's attempt to fit women into a white-gay-male model of AIDS which "cannot address the central physiological and sociopolitical differences between the sexes, namely that AIDS like many sexually transmitted diseases, immerses women in complex fertility and reproductive decisions" (Corless, 1988, p.66).

Much of the language used to contain women's fears about AIDS is offered predominately by male doctors and is often couched in a dialogue which serves to overlook women's reality and sexual experiences. As Robert Connell (1987,p.251) points out, medical discourse and "medicalization have had a double effect. It depoliticized gender relations directly, while building a more mediated power-structure based on the authority of a masculine profession". Women subsequently remain a largely overlooked area of medical research, and in particular, of the AIDS research agenda. In the case of HIV/AIDS, it is almost exclusively these male 'experts' (doctors, epidemiologists, etc.) who decide the direction and application of the language of AIDS. Julia Penelope (1990) describes this language differential as the patriarchal universe of discourse (PUD). More specifically, she refers to PUD as a system which "provide[s] the conceptual framework that imposes meanings and interpretations on what we perceive. The model provides descriptions of what the culture believes to be important categorizations of those objects, events,

ideas, and beings which give their 'place' in the world and assigns certain values to behaviours" (p. 56). In this manner, specific (and often times marginalized) groups become codified into the language of AIDS as it encloses around them (e.g., gay men, IV drug users, prostitutes). Or conversely, as in the case of women, the same language can be used to keep women's health concerns outside the legitimate realm of medical research and discourse.

Issues raised by feminist research on gender and sexuality suggest that the power differential between men and women inhibits the utilization of effective AIDS preventive strategies, such as condom use or non-penetrative forms of sexual expression (Levine, 1990). Some researchers such as Laws and Schwartz (1977) suggest that this power differential is rooted in institutional practices such as compulsory heterosexuality, marriage and the family, the law and medical sciences, which all serve to reaffirm women's subordinate position within sexual scripts and within society more generally. "In traditional (sexual) scripts for women, sex is always for the sake of something or someone else, not for oneself" (Laws and Schwartz, p. 130). These 'traditional' sexual scripts in turn serve to reduce women's sexual autonomy and limit sexual practices to the realm of penetrative sex. Negotiating safer and more pleasurable sex thereby becomes a highly charged and often times impossible topic to broach (Patton, 1994).



For other feminists, the inability of women to negotiate or assert their sexuality in their relations with men serves to create an image of AIDS preventive strategies as a largely political issue as opposed to an issue of sexual pleasure and safety (Campbell, 1990; Haug, 1987; Patton, 1994). As Weeks (1986,p.60) points out, "males in becoming men, take up positions in power relations in which they acquire the ability to define women". In defining what constitutes female sexuality, men have narrowly prescribed the narrative of penetrative, procreative 'hetero-sex' for women while eradicating the possibility of balance between sexual pleasure and sexual safety (Holland, 1990). For many women therefore, convincing their male sexual partners to practice safer sex, including non-penetrative sex, and to participate in more pleasurable, reciprocal sex are key obstacles to overcome in attempting to remain sexually active and HIV negative.

The socially constructed, rigidly defined concept of female sexuality ascribed to young women is therefore regarded as a crucial link in addressing the ability to avoid HIV infection and is often cited as a central factor in the spread of HIV infection within this population (Campbell, 1990; Kippax et al., 1990, Moore and Rosenthal, 1992; Patton, 1994). The concomitant issues raised by Kippax et al., (1990) suggest that the socialization of young women to believe that their sexuality is dichotomous

with the "wife/mother" versus the "whore" role leaves very little area for women to manoeuvre their sexual desires or pleasures into the equation, let alone the issue of safer sex. "Unregulated sexuality is accepted for males, from females whose sexual stability is the sine qua non of our family concept, however, extramarital or premarital sex threatens the basic structures of society" (Laws and Schwartz, 1977, p. 195).

Heterosexual identity, according to Cindy Patton (1993), is an institution and an ideology which has been imposed on women and which restricts so-called 'normal' sexual activity to phallocentric conceptions of sexual pleasure. As well, this has brought about a great deal of resistance on the part of heterosexual men towards safer sex and the use of condoms. As Patton (1994) suggests, heterosexual men regard 'ordinary' heterosexual intercourse as a safe activity, whereas homosexual activities of any description are considered inherently risky behaviours.

This sexual dichotomy based on heterosexual conventions of what are considered to be sexually appropriate behaviours further problematizes women's ability to practice safer sex. If men do not perceive themselves to be doing something sexually 'unnatural', then the need to use latex or non-penetrative sex does not apply to them. In order to 'normalized' safer sex for women, heterosexual men will have to be convinced that safer sex doesn't mean less pleasurable

sex. In fact, Patton goes further to suggest that heterosexual men may need to become just "queer" enough to practise safer sex.

### AIDS Prevention

Many AIDS education and prevention messages are not utilized by young sexually active women. The reasons for this are complex and vary not only from one context to another but also from one individual to another. According to the Canada Youth and AIDS Study (1989), AIDS education has been largely ineffective in preventing the spread of HIV among young Canadians. When attempting to address the illusion of invincibility among this age group, the Canada Youth and AIDS researchers describe the futility of safer sex rhetoric directed at teen culture.

For most young people the belief that it will never happen to them has lulled them into a false sense of invincibility with respect to the adherence to safer sex messages. As Keeling (1987) suggests, "[i]t is well known that young people in many instances take unwarranted risks because they are convinced that the consequences 'can't happen to me.' Thus, even sexually active young men and women who acknowledge their behaviour may not take adequate precautions to prevent HIV transmission" (Keeling, p.27).

However, as Hein (1991) has pointed out, AIDS education

for young adults must attempt to prevent the further spread of HIV while recognizing that a primary goal of adolescence and young adulthood is to develop the kind of sexual attitudes and experiences that shape healthy sex-positive adult relationships. Our efforts to inform young adults and adolescents about HIV and AIDS should not produce a generation of people who are afraid of intimacy, instead we must try to incorporate the lived experiences of these young people into relevant safer sex messages.

Many researchers have been able to gauge the level of knowledge regarding HIV and AIDS and have found most young adults to have very high levels of AIDS awareness or 'common sense' knowledge, but a considerably lower application of this knowledge (Keller, 1993; Holland et al., 1990; Heinrich, 1993; Ornstein, 1989; Patton, 1994). For AIDS education messages to be effective and to change both attitudes and behaviours, we need to understand how young adults make sense of their sexuality and sexual risk taking behaviours. To do so, we must look to the work of social construction theorists when attempting to bridge the gap between knowledge and actual behaviours.

## Social Construction Theory

The importance of social construction theory for the purpose of research on women and AIDS is that it affords us the opportunity to start from the everyday, lived experiences of young women based on how these young women make sense of their sexual reality. Rather than imposing a rigid set of definitions about female sexuality and the parameters within which it must operate, social construction theory allows the subject to define and describe their lived, 'real world' experiences.

The ability of young women to describe and define for themselves is crucial to this research for it allows them to express what they know and believe about sex, specifically what they think is natural, proper and desirable (Holland et al., 1990). For Holland the assumption is that sexuality, although inextricably linked to the body, is socially constructed in ways that makes it 'real' to us, and this reality exists beyond our own individual bodies.

According to Schutz (1989) in The Structures of the Life-World, reality is socially constructed in a manner not of our making but rather it is learned and accepted as our reality, in part, through the process of social interaction and internalization. Schutz explains this process of reality formation quite clearly:

The world of everyday life is taken for granted by our commonsense thinking and thus receives the accent of reality as long as our practical experiences prove the unity and congruity of

this world as valid. Indeed, even more, this reality seems to us to be the natural one, and we are not ready to abandon our attitude toward it, unless a specific shock experience compels us to break through the limits of this finite province of meaning and to shift the accent of reality to another one (p.286).

Berger and Luckmann (1966) go further by suggesting that only a small fraction of what is referred to as "the stock of knowledge" at hand originates from the individual's own experiences. Most knowledge is socially derived and has been handed down from generation to generation. In this manner reality is socially constructed and reinforced through interaction with others, while at the same time continuing to appear 'real' to those around it until such time as we are compelled to change this reality.

As Guba (1990) suggests, the benefit of using a constructionist methodology is that it moves the inquiry process out of the laboratory and into the natural context "to discern meaning implicit in human activity, and to be congenial to the human-as-instrument;...that theory must arise from data rather than preceding them; and that the method must be hermeneutic and dialectic, focusing on the social processes of construction, reconstruction, and elaboration..." (p. 78).

The contrasts between a positivist and constructivist research paradigm demonstrate the potential conflict between method and results. For instance, while the positivist approach maintains a realist ontology, and an

interventionist methodology, a constructivist approach employs a relativist ontology, and a hermeneutic methodology. The benefit of utilizing a social constructionist perspective for the study of female sexuality is the acknowledgement of reality as a social construction with no one single reality. It allows for the existence of a variety of meaning-bounded constructions of reality based on the individual's experiences (Holland et al., 1994).

According to social construction theory, sexuality is not regarded as a biological given "determined by our organs, but rather it is a profoundly unique product in which bodily sensations are linked to sexual acts, identities and meanings in ways that are fluid and changeable over time" (Vance, 1989, p.13). As well, this theoretical perspective calls into question accepted ideological frameworks for the examination of 'facts' about both sex and gender. For Foucault (1978,p.194), this moulding of sexuality also includes such seemingly desperate spheres as "discourses, institutions, architectural arrangements, regulations, laws, administrative measures, scientific statements, philosophic propositions, morality, philanthropy, etc..".

### Chapter 3

#### Methodology

##### Participants

The ideal location to recruit young sexually active females to participate in this research was through local teen health clinics, group homes and university residences. Since the focus of this research is on young women, the age range of participants was limited to participants aged 15 to 23. All three locations would allow for the study of young women within this age range. Initially, the primary location of interest for this research was The Teen Health Centre due to the nature of the services they provide and the age of the population they serve. For instance, among The Teen Health Centre's broad range of health-related and medical services, it offers counselling and information on sexuality issues such as contraception and STDs. Approval was given by The Teen Health Centre to distribute questionnaires to their female clients through the nursing staff.

The purpose of distributing the questionnaires to this population was two-fold. The primary purpose was to gain access to teenage female clients to fill out a knowledge, attitudes and behaviours (KAB) questionnaire on HIV/AIDS, and the second reason was to request an interview with those young women who were willing to meet for an hour to discuss



sexuality and AIDS. While The Teen Health Centre was willing to distribute the questionnaires, they were reluctant to allow access to respondents for the personal interviews. Due to the problem with access for the interview portion of this research, it was necessary to withdraw The Teen Health Centre from the project.

As a result of the issues faced by the researcher at The Teen Health Centre, the assistance of the Manager of Student Residences at The University of Windsor was sought in order to gain access to first year female students living in residence at The University of Windsor. The Sandwich Community Health Centre was also contacted, however, due to time constraints they were unable to participate. The director of Maryvale, a local group home which provides services for adolescents who are experiencing emotional and behavioural problems, was also contacted for possible participants.

Approval was given by the residence manager at The University of Windsor to distribute the questionnaire following a meeting with the residence dons. Following a brief introduction and presentation on my research, I asked volunteers to fill out the questionnaires and to give a name and phone number if they wished to be interviewed. A total of 325 questionnaires were filled out by young women. From these 325 completed questionnaires, a total of 20 young women agreed to participate in an hour-long, open-ended

interview. Of these respondents, one was from a local group home (Maryvale), four were recruited through the Women's Centre at the University of Windsor and the remaining fifteen were from the female residences on campus.

The one respondent from a local group home was interviewed and completed the questionnaire at her group home. All other interviews took place in a private interviewing room at the Women's Centre at The University of Windsor. While conducting the interviews at the Women's Centre at the university, four other interested young women were recruited to fill out the questionnaire and all four agreed to participate in the interview. Of these 4 young women, 3 regularly frequented the Women's Centre and were undergraduate students at the university. The fourth respondent recruited at the Women's Centre was not a student at the university at the time of the survey.

Of the 20 participants, 14 described themselves as heterosexual, 1 as bisexual and the remaining 5 self-identified as lesbian. The age range of these participants was from 15 to 23 years. The average age of the participants was 19.7 years. Eighteen respondents reported being single, and two lesbian respondents reported being in long-term relationships.

Not surprisingly, given the nature of the recruitment, 14 respondents reported living in residence, (including one who was living in a group home), while only 1 reported

living with parents and the remaining 5 reported living in their own or shared apartment. The names of the respondents have been changed to protect their identity.

#### Data Collection

Originally, the data were to be collected in two ways. The first method was to have students fill out a KAB-type questionnaire on HIV/AIDS knowledge, attitudes and behaviours which included questions on background information and a consent form. However, after reviewing the material garnered from the 20 in-depth interviews, a decision was made to concentrate on this information as the principle means of bridging the gap between levels of AIDS knowledge and actual behaviours. It was felt that the interviews would allow for the reporting of greater detail in terms of actual sexual behaviours and interactions experienced by the respondents. As well, the interview process is particularly well suited to the exploration of sexuality from a social constructionist approach (Marshall and Rossman, 1995). As a result, the KAB questionnaires were not fully analyzed.

The interviewing process allowed for the exploration of themes regarding how sexuality is constructed and understood which would not have been possible with a KAB-type questionnaire. It is these 'constructions' and resultant

behaviours, including how they are maintained in the face of AIDS which present the crucial 'jumping-off' point from which to develop effective safer sex strategies targeted to women of this age group. As a result, only the background information from the questionnaire on age, level of education, where the respondent lived, their marital status and sexual orientation was incorporated into this research. All other information was derived from the interviews with the participants.

All interviews were audio taped with the permission of the respondents and were approximately one hour in duration. The interviews were conducted during the day and at times requested by the participants. An open-ended, semi-structured format was used to explore a number of areas relevant to sexuality, and safer sex in particular. These areas covered issues concerning the respondent's perceived level of risk for HIV infection; the degree of control the respondent felt she had in her sexual encounters; how she felt about unprotected sex; if she experienced any pressure to have sex, (whether unprotected or protected); who she would talk to about safer sex, as well as other AIDS-related issues.

Although there were a number of questions asked about specific aspects relevant to AIDS and safer sex, respondents were given the opportunity to discuss issues of concern to them which may not have been brought out in the interview

schedule (see Appendix B). This process allowed respondents to centre themselves in their experiences without fear of being cut off or redirected to a specific question or area. Respondents were also given the option of not answering any questions. However, all participants were willing to provide responses to every question and on every area explored.

Once the interview was completed, each respondent was given an opportunity to discuss her feelings about the interview process and to ask any questions she had with respect to my research on women and AIDS. As well, copies of AIDS awareness materials, free condoms, lubricant and dental dams were given to respondents to thank them for their participation. Respondents were encouraged to call either the local AIDS committee or the toll-free AIDS information lines listed in the pamphlets handed out should they have any additional issues they might want to address after they left the interview. Those who wished to contact me upon completion of this research were asked to keep my name and number which were listed on the last page of the questionnaire.

## Chapter 4

### Results

#### Interview Results

For the purpose of analyzing the data from the interviews, themes and patterns were identified based on the responses from participants. Each interview was transcribed by the researcher and notes were used to develop the themes and patterns. The verbatim transcripts were analyzed along the theoretical guidelines for qualitative analyses put forth by a number of qualitative social researchers (Marshall, 1995; Creswell, 1994; Strauss, 1987). Transcripts were divided into episodes or scenes that made vertical (within an individual) and horizontal (between respondents) comparisons possible.

Analyses of this type of material not only takes these accounts at face value, but also involves the identification of recurrent themes in separate accounts. This latter exercise permits the formulation of themes and processes which are regarded as significant issues for the respondents. Six main themes or patterns were derived from the data. These were: risk assessment, intentions, interaction, trust, pressure, and responsibility.

## Interpretation of Themes

### Risk Assessment

Respondents were asked to describe how they thought they might be at risk for HIV infection (or not), if they practised unprotected sex, if it was their choice to have unprotected sex, and how they rated their own risk for HIV infection. Most participants felt they were not at risk for HIV infection. When asked why they felt they were not at risk, most heterosexual respondents explained that didn't use injection drugs, have sex with gay men, and more directly, because they were having 'normal' sex.

According to research by Westerman et al. (1993), homophobic attitudes may help to create a belief that young heterosexuals are not at risk for HIV/AIDS because they still regard it as being a gay men's disease. The designations 'gay' sex, or 'deviant' sexual practices have had tragic consequences for women in that receptive patterns of intercourse, regardless of gender, are considered high risk for HIV infection. As Patton (1994,p.29) points out, this has served to "mystify women's risk by inappropriately describing heterosexual 'contact' devoid of the reality of vaginal or anal reception of semen".

Nearly all respondents felt they were not or were no longer at risk for contracting HIV based solely on their sexual behaviours, even though much of their reported sexual

behaviour could be considered 'unsafe' according to the Canadian AIDS Society safer sex guidelines. It is interesting to note that while many respondents, both heterosexual and lesbian, felt they were highly knowledgeable about HIV/AIDS, they felt that it was not necessary to practice safer sex given the nature of their sexual relationships. The possibility that one's sexual partner may not divulge certain information on their sexual or drug use history did not enter into the discussion on sexual safety for most of these women.

For lesbian respondents, their sexual safety seemed to be assured through their lack of sexual contact with men, the monogamous nature of their relationships with their female partners and their lack of drug use. As a result, most lesbians felt that HIV/AIDS was more of a concern for their gay male friends or 'straight' female friends than it was for them. For instance, one 22 year old lesbian expressed her thoughts on risk for HIV infection and her sexual orientation this way:

I've thought about that before I got information on women and AIDS but to be honest with you, being a lesbian and everything I didn't stop to think I'd be at risk I guess. I figured I'd be the lowest risk factor and it would be highly unlikely given my sexual practices to date

Margaret, age 22

However, Margaret also went on to express her concern over the possibility that she could be at risk because of



her partners' sexual or drug history. This conflict between sexual practices and sexual identity became more apparent as other themes were explored. In fact, for many individuals their risk assessment was clouded not only by issues of sexual identity but also by the belief that they did not know of any HIV positive people in their immediate circle of friends and were therefore unlikely to ever have a sexual partner who was HIV positive. This resulted in many inconsistencies not only within individuals' accounts, but also among individuals in terms of assessing their own personal risk of HIV infection.

The following comments made by a 20 year old lesbian also demonstrate how the conflating of risk and sexual identity may serve to reduce one's personal assessment of HIV risk:

Um, no I don't feel I'm at risk, but actually HIV is not the major thing I worry about, it's other things that you can catch. I know myself that being a lesbian is low risk, lowest risk to HIV, so that's not the first thing that crosses my mind, but yeah, it does cross my mind sometimes cuz I know that there are rare instances where you can catch HIV if you are a lesbian

Diane, age 20

One 16 year old lesbian expressed her opinion on risk based on her safer sex practices as opposed to her sexual identity or group membership. "No, I am not at risk because I practice safer sex, so actually no, I am not. I use dental dams".

For heterosexuals, the use of HIV antibody testing as a means of gauging when to use condoms continues to have tragic results for women in attempting to remain HIV negative. The use of HIV antibody testing is no guarantee that either partner has not already been exposed to HIV. In fact, if a partner is tested and is found to be HIV negative, often this is sufficient grounds to remove any possibility of risk for HIV infection (Patton, 1994). As well, those who initially did use condoms with a partner usually stopped doing so once a relationship was established. What is often overlooked by those who use the process of HIV testing as a safety mechanism is the 'window period'. The window period is the time between being exposed to HIV and the newly infected body producing HIV antibodies. This lag time may allow those who have yet to develop HIV antibodies to test HIV negative even though they may have HIV in their system and can pass it on to others during unprotected sex without knowing they have done so. In fact, it will usually take three months for sufficient antibodies to develop before they will be detected by an HIV antibody test (AIDS Vancouver, 1994).

Attitudes towards testing as a safety guideline or justification for when to practise safer sex (or not) is clearly evident in the response of one heterosexual participant. Barb adamantly stated that she was not at risk for HIV infection due to the monogamous nature of her

relationship, as well as having been tested for HIV.

No. Cuz I'm in a monogamous relationship. I've been dating the same person for three years and we've both been tested so, I consider myself risk-free

Barb, age 22

However, when questioned further Barb suggested that she could be at risk if her partners went outside the relationship for sex. Although she hoped her boyfriend would never 'fool around' on her, she quickly added that she would probably never know if he had.

Risk assessment was not only determined by the respondent's sexual orientation or the type of relationship, but is also determined by their belief in monogamy as a form of safer sex. As a 19 year old respondent explains, her risk for HIV infection was assessed by her boyfriend's faithfulness.

Right now...no not at all cuz I'm not sexually active with anyone now. So in the past I was at risk. I was involved with a guy, I was very young. I was 16 and we were going out for a couple of years and during that time we never used a condom at all and he slept around a lot and when I found all that out I realized that I was scared cuz I thought I don't know how many girls he slept with so I went for an HIV test. I've learned my lesson. So my current risk is zero

Shelly, age 19

Another young heterosexual respondent stated that her risk assessment was largely dependent on the situational or contextual factors she was faced with.

Sometimes I feel I'm at risk, not often because I use protective sex - just in case the condom breaks or if I don't have a condom with me and I wind up having sex, but usually I don't so my risk is pretty low

Kathryn, age 15

Kathryn also mentioned that she could not 'control' the use of condoms if her partner resisted. Even though she felt she was not at risk, she realized that the variability of factors within her sexual contacts placed her level of risk outside her control.

For many respondents their risk assessment was heavily influenced by situational factors which, as Kathryn described, were thought to be largely outside of their control. Several individuals, including Kathryn, felt the need to qualify their answers in a way that resulted in an unclear message of perceived risk.

Another 19 year old heterosexual respondent also suggested that her sexual safety was determined by her partner's actions and perceived risk level.

No. Um, because there is only one person that I ever had sex with, we did actually go twice to have him tested for HIV because we did think he might be at risk. And we waited a long time for the test results and then had another one done to make sure

Suzy, age 19

A 21 year old bisexual respondent felt she was at risk for HIV infection and she summed up her reason why this way:

Um, yeah. Well, um, just recently we had some people come to our dorm, doing a seminar on AIDS and one of the things that they stressed

was the uh, intoxicated sex is not safe sex. So, I've had my share of intoxicated sex. Like, but, my rule is protection or no, but I can think of three, four times, in the past maybe two years that it's happened where there has been no protection. So, yeah

Betty, age 21

### Intention to Use Safer Sex

Respondents reported their efforts to use safer sex (usually a latex barrier or non-penetrative forms of sexual interaction) had at some point been thwarted by their sexual partners' insistence that they need not use such precautions. The process of rationalizing away the need for safer sex was done by keeping the concept of infection at arm's length. And although most respondents expressed a strong desire to use safer sex, often they were afraid to disturb the love-making process once it had begun. In other instances, the respondents felt that non-penetrative forms of sexual expression would have been preferred but were unable to gain their partners' compliance. It is interesting to note that for many of the heterosexual respondents interviewed, sexual interaction up to the point of, but excluding penetrative sex was regarded as most pleasurable. For many women it was felt that this strategy of non-penetrative sex could keep them relatively 'safe' from pregnancy and STDs. However, these same respondents also pointed out that according to their male

partners 'sex' had not occurred unless penetration took place. The different ways young women attempted to practice safer sex were often undermined by the emphasis on penetrative forms of sex as 'real sex'.

For most women they lacked the translation of a general intention to practice safer sex or non-penetrative sex into a usable strategy. Therefore, the shifting of priorities during sexual intimacy was not possible for most women. Situational factors also played a role in the intention to use safer sex. For instance, sex while under the influence of alcohol often resulted in sex without a condom on a first date, and being away from home for the first time resulted in more unwanted sexual interaction.

One respondent described how her intention to use condoms can change depending on the situation. For example, if condoms are not readily available, or if the other person doesn't care if a condom is used or not, then the original intention to use them is lost.

Like you know, just not having one on you and not wanting to make a big deal about it. Sometimes it's just too much of a hassle, so you say don't worry about it

Carol, age 20

When asked why a person would change her intention from condom use to feeling it is unnecessary, one respondent suggested that it is largely as a result of not feeling they were at risk with that particular sexual partner or feeling afraid to bring up the topic. As well, it is not easy to

change intentions when the mere thought of resistance from their partner is more of a 'turn off' than the thought of unprotected sex.

Most people just look at the person in front of them and say, well he's clean cut, he doesn't have AIDS. So I think that is why a lot of my friends don't push their desire to use them (condoms) plus they are on the pill and are more worried about pregnancy and they don't think their partners have AIDS. It's a big turn off for guys to be told what to do when it comes to sex

Nicole, age 22

### Interaction

Since sex with a partner involves interaction, whether verbal or physical, it is open to interpretation and dispute. In fact, most respondents feel that their intention to practice safer sex is often altered by the type of interaction they experience with their partner. For example, with a new sexual partner, many respondents choose to 'wait and see' what would happen sexually. In many cases, situational barriers resulted in communication about safer sex being blocked. In some instances, the respondents enter into the sexual interaction with every intention to use a condom but find themselves in a situation where it is not brought up and they feel too uncomfortable to broach the topic. If the sexual interaction is with a new partner, many young women expressed reluctance in discussing the subject of condoms for fear of appearing too willing to engage in sex. Even if

she does discuss it she may run the risk of non-compliance or outright rejection.

Many young women feel too embarrassed to ask their partners to use condoms. As Holland et al. (1993) suggest, condoms carry with them symbolic meaning and this meaning is likely to differ from partner to partner as well as over time. Even if the interaction is more positive and communication is open, most respondents reported the need to feel out their partners' reaction regarding safer sex before suggesting condom use. If the reaction is not favourable, often this is sufficient grounds to drop the entire discussion.

As one heterosexual respondent describes her sexual interaction with a partner:

It was one of those things. He kept going on and on about it and I kept saying, "no". But I kept going with it, it was, I think I wanted to, but I didn't want to without a condom, and I wanted him to kinda con me into it, but I did it.

Sally, age 20

Sally also suggested that part of her willingness to allow herself to be 'conned' into sex is based on her desire to have a boyfriend, and for her this meant going along with the interaction. Sally added: "I really wanted some attention and I thought he could give it to me. It was a trade-off, he won, I lost, cuz I never saw him again". Many women, including Sally, expressed frustration at the contradiction between her needs and desires and those of her



partner. In fact, several respondents reported feeling ill at ease with the notion of 'directing' their sexual interactions with their partners in an effort to increase their own sexual pleasure. Most respondents reported not feeling like they 'deserved' to be sexual outside of their sexual interaction with their boyfriends. As well, many young women reported that their own sexual gratification was not as important as pleasing their partner during sexual interactions. A lack of sexual autonomy or the ability to control the sexual interaction with a partner was reported by many respondents as a central problem in terms of both safer sex and sexual pleasure.

Another young woman reported feeling sufficiently uncomfortable about the topic of safer sex and condoms that she simply avoided the topic whenever possible. Part of this reaction was based on her negative experiences with a previous partner when she expressed her desire to use condoms.

I would feel bad, not that he would pressure me not to but I didn't want to start anything, you know, getting into that. My previous partner, it would be a five minute conversation 'you're on the pill, don't worry about it'. I wouldn't get really into it which isn't a good thing, I know.

Betsy, age 19

For Betsy the conflict between her desire to practice safer sex and her partner's wishes not to resulted in her acquiescing for fear of upsetting her partner. This

contradiction between knowing about safer sex practices but not implementing them is a source of anxiety and frustration for many respondents.

The variability of sexual interaction and adherence to safer sex has led some young women to motivate their partners to use condoms by telling them they are not on the pill when in fact they were. Others attempted to remain 'safe' by limiting sexual involvement to 'monogamous' relationships.

For me it doesn't really happen unless it is a monogamous relationship and I am on the pill and even then I still have my doubts so I try most of the time to make sure it is protected and if not I have concerns and I worry. I'd rather be protected if I had a choice and could talk about it. I try to be in control of that.

Kate, age 19

Kate also described how she had been coerced into having unprotected sex outside of her monogamous relationship but added that if she had had a choice she would have 'preferred' to have "at least used a condom".

### Trust

As has been demonstrated by other research on AIDS (Maticka-Tyndale, 1992; Ehrhardt et al., 1992; Fraser, 1994; Kippax et al., 1990), trust can have very different meanings for men and women. Most young women believe that their partners can be trusted to disclose risk-related information about their sexual histories. And as Maticka-

Tyndale's 1992 research findings suggest, given the difference in meaning of the concept of 'trust' between men and women, trust alone is an insufficient means of protection against HIV or other STDs.

Many of the young women interviewed for this research described the issue of trust as central to their sense of self-worth in their sexual interaction with their partners. Most respondents described trust as being a major influencing factor when it came to practising safer sex. According to these young women, as the relationship develops so too should the level of trust. With increased trust come the notions of monogamy and love. Most respondents believed that because of this combination of love and monogamy, they were able to trust that their partners would not do anything that would put them at risk.

I'm in a monogamous relationship, and maybe it's naive, but I trust him completely, I don't think he would ever put me at risk. I think if he was ever to be in a situation where he was going to be with somebody, he would be concerned about putting me at risk

Nicole, age 22

Nicole also added that because of her monogamous relationship with a partner she can trust, she stated that they "don't need to use condoms any more cuz there's no risk". However, Nicole also suggested that she was worried that if she didn't have sex with her boyfriend, "he might get it elsewhere".

As the level of trust increases, the perceived

need to practice safer sex becomes less important. In many instances, the fact that most heterosexually active young women are on the pill makes the argument for condom use an issue of trust rather than one of sexual safety. From the information gathered in the interviews, it appears that if both partners trust one another to be faithful, they feel there is no longer a need to worry about HIV or other STDs and therefore no need to continue to use condoms.

It is this sense of being able to trust one's sexual partner which has served to rationalize away many young women's desires to practice safer sex. As a result, many respondents who were in what they described as 'trusting relationships' no longer felt the need to continue to put their sexual safety first and were lulled into the false belief that trust is sufficient to prevent them from contracting HIV or other STDs.

Another young woman responded to the issue of trust as it relates to pregnancy. For those young women who disclose that they are on the pill, they should 'trust' that their partners will not give them an STD and therefore using condoms in such situations symbolizes a lack of trust.

Oh, well, to tell you the truth, a lot of guys listen to my concerns about pregnancy but when they found out I was on the Pill that was fine, why use condoms too, whereas when it comes to HIV and AIDS I mean the guys are young and they think they are immortal and they don't think they could have HIV so that is just brushed off with "if you trust me" or "if you really love me"

Sally, age 19

As Sally points out, the confusion over when to use safer sex is further problematized by equating trust with love. The logic for many respondents is, as Sally suggested, "if their partner really loves them, they ought to be able to trust one another". For her to have unprotected sex with her boyfriend demonstrates both a 'blind' act of love and trust.

For many respondents there was a fine line between trust and pressure when it came to practising safer sex. Often the two are mixed together in a way which creates a sense of powerlessness for the women as they try to gain compliance with their sexual partners.

### Pressure

Most of the respondents felt they had been pressured into having sex at some point in their lives. For most women this 'pressure' involved being coerced into having sex or to engage in specific sexual acts they did not wish to participate in (Kippax, 1990). For the young women interviewed the pressure to have sex ranged from pleading and guilt-tripping to hostility and anger. Regardless of the degree of pressure experienced, most women felt they were not able to persuade their partners to discontinue sexual intercourse once it was attempted.

This was particularly true for young women who did not

want to 'go all the way'. Many respondents felt that petting and kissing were quite acceptable and pleasurable, however once intercourse was attempted, they expressed frustration and fear at not being able to change their minds for fear of appearing to be a 'cock tease' or being accused of leading their partner on. However, some lesbians reported overcoming the pressure to have sex with open discussions about their feelings and desires.

As Diane, a 20 year old lesbian explains:

I think it depends on whether or not it's casual or a relationship. I think it would be way harder if it's casual cuz you supposedly just are there for sex, you know. In a relationship I can talk to my partner no problem. You just have to talk about it, that's all. How else is your partner supposed to know what you like or don't and stuff like that.

Betty, a 21 year old bisexual explains her experience with coercion and unprotected sex almost as a given.

I've never come across anyone yet who was like violently hostile, but the pouting and the guilt trip sorta thing. I've been coerced into having unprotected sex, definitely.

One young lesbian explains that, even when she expressed her lack of interest in having sex with one young man, she was pressured into having penetrative sex against her will while living in residence.

I had been forced to have sex when I was in residence. It was sort of like date rape. I just met him that night and we didn't use any protection. It was kind of hard to bring up the topic of protection when you're being forced into having sex when you don't want it. When you keep saying no no no and he just continues

anyway.

Heather, age 21

Another young women describes a situation where she was forced into having unprotected sex:

Yes I was forced. I was 16, it was a party and I was drinking and I passed out and when I woke up this guy was on top of me and he didn't use a condom and I wasn't on the pill or anything like that. It definitely wasn't my choice to have unprotected sex.

Shelly, age 19

### Responsibility

Most young women felt they were responsible for their own protection when it came to pregnancy but felt that safer sex and the use of condoms should be a shared responsibility. Some women expressed concern over the fact that not only were they responsible for pregnancy prevention, they were also responsible for supplying condoms because they could not count on their partners for any level of consistency with respect to these issues.

I think it is my responsibility, because sometimes, as much as your partner may care or love you, sometimes you don't think about those things, especially guys sometimes don't think about the pill or condoms or anything like that. I try to discuss it with my partner but I'm the one to take responsibility.

Lori, age 19

Another nineteen year old expressed her concern about responsibility this way:

Well for me I take responsibility but then again if I get into a long term relationship there is a shared responsibility. A lot of guys do come prepared these days, that's fine but I think you should always protect yourself because you don't want to be in a situation with a guy you don't even know

Shelly, age 19

Those who felt it was their responsibility to protect themselves often qualified their answers with the realization that even if they did want their partner to be equally responsible it was unlikely to occur. The expectation that the other person would be equally responsible for their own protection was often quite low or non existent.

You should always be responsible for yourself, you don't rely on anyone else. In my situation, it was a shared thing, a combined effort, we both brought something, so that it was there. Which is good cuz it means he was trying to be responsible as well, but I would never expect him to, well, like I mean please, I don't expect them to do that because they probably wouldn't

Suzy, age 19

As another young respondent put it:

Never expect it of men. I mean, you know, if I'm there, I always carry a condom, if I don't have one in my pocket it's a big surprise

Sally, age 20

A 16 year old lesbian expressed her beliefs about responsibility this way:

It's my responsibility to protect myself. If it's a stranger, I wouldn't go to bed with them anyway

Joanne, age 16



For some women, the fact that it is up to their male partner to actually use the condom, their level of 'responsible' behaviour is largely dependent on their partner's level of responsibility.

I do believe it is our individual responsibility. Since I use condoms I guess I would be more dependent on my partner since they are the one who has to put it on. If I have been dating someone for awhile, ideally we would both get tested. If we are disease free I would acquiesce.

Alice, age 23

## Chapter 5

### Discussion

The analysis of patterns or themes in this research uncovered some of the complex issues faced by young women in attempting to negotiate safer sex. As well, a number of expected outcomes were realized by this research. For instance, previous KAB-type research on AIDS has demonstrated that high levels of 'common sense' knowledge about HIV/AIDS do not readily translate into useable safer sex strategies (Baldwin, Whiteley, & Baldwin, 1990; DiClemente, 1990; King et al., 1988). Knowledge of HIV/AIDS was just one of a number of factors fleshed out in the interviews through the recognition of recurring themes or patterns described by the respondents. Overall, the levels of knowledge expressed by the respondents were high. However, there were considerable internal contradictions found within the responses of many respondents. As a result, the application of safer sex knowledge was quite variable based on the context of the sexual interaction and the individual involved.

The six main themes investigated for this research which looked at the barriers associated with the application of HIV/AIDS knowledge and practices were: risk assessment, trust, intentions, interaction, pressure and responsibility. A closer look at these issues helped to create a better understanding of the obstacles faced by young women as they

attempt to incorporate safer sex into their sexual repertoire.

For most participants in this study, the remoteness of HIV infection to their sexual experiences, whether well founded remoteness or not, appeared to be sufficient grounds for not practising safer sex. Most young women interviewed believed that it was virtually impossible that someone with HIV/AIDS could be part of their immediate sexual sphere, given their sexual practices and relationships. However, upon closer investigation of the respondents lived experiences, it seemed that the need to keep HIV and AIDS at arm's length is, in part, due to the lack of power to change their immediate sexual circumstances. For many women it would appear that understanding and acknowledging the importance of safer sex is not the problem per se. For most women, it was the interaction with their partners, especially male partners, which caused many women to drop their intention to practise safer sex. And while most women expressed the desire to feel some sense of control over their sexual expression in order to remain 'safe', most were unable to enforce this desire when faced with an unreceptive partner (Laws and Schwartz, 1977).

Many women underestimated their risk for HIV infection based on either the need to reject any sense of personal harm or because they did not feel adequately equipped to overcome the obstacles they faced in their sexual

interactions. The contradictions between desired sexual safety and self-reported actions demonstrates the ongoing tension between AIDS knowledge and safer sex behaviours. These contradictions expressed themselves in a lack of action with respect to sexual safety. The internal conflict expressed by individuals with respect to their sexual identity and sexual behaviours pointed to a number of complex contradictions faced by women in their attempts to practice safer sex.

Based on the interviews, it appears that many young women are still adhering to the risk group paradigm and therefore do not regard their behaviour as a possible source of risk for HIV infection. The advantage of this strategy for these young women is that it enables them to rationalize away their potential for HIV infection by adhering to the notion that 'proper women' don't have sex with gay men, injection drug users or even bisexuals. However, the disadvantage of this strategy is that by regarding HIV/AIDS as a concern for 'others' based on their group membership, young women overlook the mechanics of HIV infection and thereby fail to realize that it is not membership in a given group that puts one at risk, but rather it is specific types of sexual and drug using practices which can lead to seroconversion. Since most women felt able to 'size up' their sexual partners based on appearance, reputation or by social class, these myths still need to be addressed in AIDS

education messages directed at young women (Patton, 1994).

The attitudes held by many of the respondents with respect to risk for HIV infection reduced the chances of practising safer sex. And, since most felt they were not at risk because of the type of sexual partner or the type of sex they have with these partners, the need to practice safer sex was overlooked by many respondents. For most heterosexual respondents they believed 'risk' was a byproduct of promiscuity and not as a direct result of unprotected sex with their 'regular' male partners.

According to the lesbians interviewed, risk was perceived to be closely linked to sex with men and not with their sexual interaction with other women. However, as Einhorn and Polgar (1994) point out, many contradictions remain between individuals actual sexual behaviours and their self-defined sexual orientation. In fact, their study of 922 American lesbians found that less than half (47%) had had sex only with women since 1978, while another 40% had had sex with both women and heterosexual men. In addition, 13% of these self-identified lesbians surveyed reported having had sex with at least one gay/bisexual man since 1978. These findings reiterate the need to move away from the risk group paradigm and to a focus on risk behaviours.

In terms of trust, most respondents felt that the level of trust determined the level of condom and dam use. For those who were in monogamous relationships, not using

condoms or dams was regarded as a means of enhancing intimacy and facilitating trust. Trust was also an important factor in terms of disclosing information on sexual histories. Those who felt they could trust their partners also felt there was no need to question their partners on their sexual or drug using histories. The issue of trust was equally important for heterosexual and lesbian respondents in terms of reducing the need for safer sex.

This research also explored the meanings associated with interaction with sexual partners and the respondents' desire to practice safer sex. Most women expressed frustration or embarrassment at trying to gain their sexual partners' compliance in using condoms. For some young women the possibility of rejection by their partners at the suggestion of condoms made the subject 'out of bounds' unless first mentioned by their partner. Once sexual activity had begun, most respondents agreed it was impossible to broach the subject. Other respondents expressed concern over seeming too eager for sex if they were to discuss safer sex or condoms with their partners before hand. For many women, discussing contraception and safer sex within the context of sexual interaction was a 'no win' situation (Laws and Schwartz, 1977).

Pressure to have sex with or without a condom or dam was an issue faced by most respondents at some point in their sexual encounters. For some respondents they had been

pressured into engaging in certain types of sexual activities they did not want. In some instances, the respondents had been sexually assaulted while under the influence of alcohol, or in other cases it was the pressure to 'follow through' which resulted in date rape. Respondents also expressed concern over their lack of control when it came to gaining compliance from their sexual partners to practice safer or non-penetrative forms of sex. In most cases, if they did not wish to continue the sexual encounter, their objections would be overlooked and sexual activity, including sexual intercourse occurred. Many respondents felt pressured into having unprotected penetrative sex because they were with a long term partner in what they described as a monogamous relationship. As Gagnon and Simon (1973) observed over two decades ago, managing sexuality involves managing interpersonal relationships. Problems arise in following safer sex practices because self-protection often conflicts with interpersonal pressures and sentiments. Based on the results of more recent research, Gagnon and Simon's findings appear to still be the case in the 1990's, even in the face of HIV and AIDS (Kippax, 1990; Holland et al., 1993; Patton, 1993; Westerman and Davidson, 1993 and others).

In terms of responsibility to use safer sex, the findings of this research suggest that it is still the women who feel the overwhelming responsibility to avoid pregnancy

and to gain their partners' compliance with condom use. This double bind results in women feeling that if they don't ask their partners to use condoms it is their fault and if they do and their partners refuse to, it is still their fault. This is particularly difficult for those who are on the pill and want their partners to use condoms in an effort to avoid HIV and other STDs (Heinrich, 1993).

For lesbian respondents, gaining compliance from their partners to use safer sex (usually a dental dam) appeared to be much easier. For those lesbians who did not regard safer sex as a concern, they too expressed a high degree of control in terms of types of partner(s) and types of sexual activities they engaged in. The lesbians in this research also expressed great ease in saying no to sex with their sexual partners without fear of retaliation.

When we consider that lesbians are operating outside the sexual norms of society and are to a certain degree, 'ad libbing' their sexual interactions, this may help to explain why these women felt more in control of their sexual interaction. As Jeffreys (1993) suggests, it is difficult for women to develop a form of sexuality which does not depend on ruling-class power. However, she adds that it might be possible for some lesbians to do so because they are sexual with other women and are thereby outside the ruling-class notion of female sexuality.



### Limitations of this Study

While the initial attempt to investigate a sample of service users at a local teen health clinic would have provided access to a more socially and sexually diverse population from which to gather information, the present study has helped develop an understanding of women's lived experiences as they attempt to remain HIV negative. However, the sample investigated for this research cannot be considered representative of females in this age range. As well, to ensure representativeness of both the lesbian and heterosexual communities, it would be necessary to increase the number of interviews conducted with both groups in order to reach a saturation point in the information gathered. As a result, the findings provided from this study should be interpreted with some caution.

The sample of young women studied in this research was based almost entirely on individuals who are connected, to some extent, with the local university. Given the relative homogeneity of this population, it would be advisable to also include more respondents from outside the university setting to ensure that women from diverse backgrounds are sampled. This is also a relatively privileged group likely to have the financial resources needed to access contraceptive and safer sex paraphernalia. Although several women of colour participated in this research, this group was also not ethnically diverse enough to speak to the

experiences of immigrant women or women whose first language was not English.

#### Recommendations

Although it is important to develop broad AIDS awareness programs about women and AIDS in order to get the message out to as many women as possible, messages are also needed which target women who are in circumstances where engaging in risk behaviours are more likely. Based on this research, the importance of campaigns which address students living in residences should be stressed. The use of peer support or 'train the trainer' techniques could be easily adapted to such populations with the assistance of AIDS organizations and universities. Other Canadian universities have already developed and implemented such programs and have found they are well received by students.

As this study illustrates, there is a need for meaningful safer sex messages and AIDS education directed at women. Many models of behaviour change stress the need to combine relevant information with motivational opportunities and skill-building experiences that equip women for sexual negotiating. The primary building blocks for such interventions combine knowledge, motivational, and skills development in a way which can provide strategies for women to gain compliance with their sexual partners.

A promising model put forth by Fisher and Fisher (1993) looks at the information-motivation-behavioural skills model of AIDS risk reduction as a means of understanding, promoting and evaluating AIDS risk-behaviour change. For most women in the present study, they have demonstrated both the information and the motivation needed to change risk behaviours, however they lack the third and perhaps most crucial element of this component of this model which is behavioural skills. The most important issue for women is the ability to discuss her AIDS prevention agenda and a pre-sex discussion with her partner and she must develop the skills to negotiate their agenda with a partner who may be unmotivated to comply with her desire to use condoms or other forms of safer sex, including non-penetrative sex.

By equipping young women with the skills to gain compliance with their partner, Fisher and Fisher, Heinrich and others believe that this will ultimately result in a shifting to sexual scripts. However, the sense of self-efficacy, or the belief that one is able to carry out these safer sex behaviours is also a necessary ingredient for the success of this type of model. For many women, they did not believe they were in a position to carry out these safer sex behaviours essentially due to their lack of perceived power to turn their desire for safer sex into a workable strategy. It may be necessary therefore to develop strategies which allow for women to negotiate safer sex in a way that reduces

the potential for conflict with partners. However, as these young women point out, the most significant barrier to practising safer sex, as well as changing sexual scripts, is the men they are sexual with. This means that in order for any model to be truly effective, both men and women need to engage in the process of sexual change and negotiation.

Since most participants in this study did not perceive themselves to be at risk for HIV infection, the first step is to overturn the myths associated with definitions of risk based on 'risk group' misinformation. The current method for sexual safety utilized by the women interviewed for this research included trusting one's partner and being in a monogamous relationship. These ineffective techniques were used to rationalize away one's personal risk for HIV. A very critical step in changing this is for women to regard and accept themselves as sexual beings in their own right and not simply as a necessary ingredient for male sexual pleasure. To define oneself as sexual is the first inroad to the realization that they are likely to engage in sexual activity at some point in the future and will therefore be in need of AIDS preventive strategies.

Further to this is the need to move away from phallogentric, penetrative forms of sex and to a more autonomous and female-centred exploration of sexuality. In order to move past the "boom-slump" model of male sexuality (Jeffreys, 1993), women will have to recognize heterosexual

intercourse as a construct which has been reified into an institution. As Cindy Patton suggests (1993,p.181), "[t]he paradox is this: heterosexual identity can only be reconstructed as truly 'safe sex' when heterosexual men are just queer enough to wear a condom".

### Conclusion

The findings of this research demonstrate the need to understand the meanings associated with sexuality and risk as women interpret them. Differences in interpretation and understanding within and between respondents based on their sexual orientation and lived experiences suggest that uniformity of messages based on gender are insufficient to evoke change in sexual behaviours. This was evident when looking at the research findings and the different responses, in particular from heterosexual and lesbians participants. It appears that gender is not the unifying source of sexual meaning for all women. The fact that lesbians expressed little concern over the threat of HIV in their own lives but felt that their gay male friends and straight women friends were more at risk signifies a need to reach lesbians and heterosexual women with different but meaningful messages based on their sexual practices and not their group membership.

Although most heterosexual respondents felt they did not have sufficient power to gain their sexual partners' compliance, many did suggest that in theory they could refuse unwanted sexual interaction. For many heterosexual women, heterosexual men were described as the most significant barrier to practising safer sex. While the importance of sexual autonomy for women cannot be overlooked as it is essential to the development of women's sexual agency, men must also be brought 'up to speed' with respect to safer sex and AIDS. As Laws and Schwartz (1977) suggest, women must continue to develop sexual agency as a means of resisting "the male initiation script and to substitute the idea that sexuality is an inherent and continuous aspect of women rather than something bestowed or episodically switched on by man" (p. 219).

Attempting to translate knowledge into effective self-protection action against HIV requires sexual negotiating skills and a sense of personal power, or self-efficacy, to exercise control over sexual situations. In these interpersonal situations, social pressures, fear of rejection and embarrassment can overturn the desire to practice safer sex by even the most adamant of safer sex advocates. For many of the respondents, the awareness of sexual assault or sexual harassment by their male sexual partners or friends was significant in keeping the possibility for control or sexual autonomy in check. The

less empowered young women feel they are to deal with the variability of sexual intimacy, the more likely they are to continue to accept the idea that they might be at risk for HIV infection. It appears from the interview data that if a young woman does not feel she can change, or at least to some degree control, her sexual encounters, she is more likely to rationalize away her feelings of risk.

Research on female sexuality and HIV has neglected to make sense of the processes by which young women understand their sexuality, and how this understanding may impact on incorporating safer sex practices into their sexual experiences. The social construction of female sexuality is, therefore, tantamount to understanding AIDS preventative behaviours employed by these young women. It is these constructs which imbue and give meaning to sexual behaviours themselves. As such, it is hoped that future research on the topic of female sexuality and safer sex will also see the value of qualitative research of this type and thereby give voice to women's concerns and experiences. As well, it is hoped that future research will address the notion that 'good girls don't get AIDS' and those who do somehow deserve it.

The value of HIV/AIDS research cannot be overlooked in terms of the development of AIDS education, and more specifically, safer sex workshops which address the need for female-centred strategies to HIV preventive behaviours. It

has become clear through this and other research on women and AIDS that the key to developing successful AIDS education and prevention programs is to engage heterosexual men in the ongoing AIDS discourse and debate.



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APPENDIX ASurvey of Young Women's Attitudes and  
Opinions on AIDS-Related Issues

Dear Participant:

We are asking for your help in a survey of attitudes and opinions on AIDS-related issues. You have been selected as part of a sample of females to receive the questionnaire. The results of this survey will be used to satisfy an M.A. thesis requirement and to contribute to AIDS knowledge and programs.

The questionnaire is answered anonymously so that confidentiality of your answers can be assured. There is a number printed on the questionnaire. Its purpose is to make it possible to keep track of the number of questionnaires in circulation and to provide you with a reference number if you wish to be interviewed.

Participation in this study is voluntary. You have the right to withdraw from it at any time and/or refrain from answering any questions you prefer to omit.

The questionnaire should take only about 10 minutes to answer. We would appreciate receiving your completed questionnaire by the end of tonight's meeting. If you wish to be interviewed, please leave your name and phone on the last page.

You will not be paid for filling out the questionnaire. However, if you choose to be interviewed after filling out the questionnaire, you will be given free condoms and safer sex information. The results of this research will be made available to you upon completion in the Graduate Secretary's Office, Dept. of Sociology and Anthropology or the Leddy Library.

Should you have any questions about this research or the questionnaire itself, please do not hesitate to contact me at 969-6785 or you may contact the Head of the Department of Sociology and Anthropology Ethics Committee at ext. 2190.

Thank you and we hope you find the questionnaire interesting to answer.

Yours truly,

Jacquie Gahagan  
M.A. Candidate  
Sociology and Anthropology Dept.  
University of Windsor

Please keep this page for your records.

N.B. I would also like to interview you if are willing to meet with me to discuss this topic in greater detail.

NOTE: By accepting this questionnaire and filling it out, you have consented to participate in this research.

INSTRUCTIONS:

1. DO NOT put your name on this questionnaire unless you wish to be interviewed.
2. Answer the questions by circling the number of the most appropriate response, and/or filling in the blank provided.  
  
Circle only ONE number for each question.
3. Place the completed questionnaire in the deposit box at the or return it to the person who gave it to you.
4. If you have any questions you can contact Jacquie Gahagan at 969-6785.
5. If you would like to be interviewed, please call me at 969-6785 to set up a time to meet.
6. Please remember your questionnaire number so that if you do meet with me for an interview I will know that you have filled out this questionnaire. You may keep the first which has your questionnaire number in the upper right hand corner.



## SECTION 1:

What follows are several questions on background information which will be used to analyze how attitudes differ by age, education, etc.

Please circle the appropriate number for each question.

1. What grade/level of education are you in/at?

1 Junior high (grades 7 & 8)

2 High school (grades 9-12)

3 Community college

4 University

5 If not currently in school, what was your level of completed education upon leaving school? (Specify) \_\_\_\_\_

2. Into what age category do you fall?

1 12 or under                      4 19-21

2 13-15                              5 22-25

3 16-18                              6 over 25

3. Where do you live?

1 With parent(s)

2 In residence (i.e., at school)

3 In own or shared apt./house

4 Other (please specify) \_\_\_\_\_

4.a. What is your  
marital status?

1 Single

2 Married

3 Common Law

4 Other  
(please specify) \_\_\_\_\_

4.b. What is your  
sexual orientation?

1 Heterosexual

2 Lesbian

3 Bisexual

4 Other  
(please specify) \_\_\_\_\_

APPENDIX E

## Interview Schedule

1. Do you feel that you are at risk of contracting HIV/AIDS as a result of your sexual practices? Why or why not?
2. Do you know what unprotected sex is? How do you feel about having unprotected sex?
3. Do you use any form of safer sex in your sexual relations? If so what are they? (condoms or dams?)
4. What types of issues do you face when attempting to introduce condoms (or dams) or safer sex into your sexual experiences? (for example, you may have faced coercion to not use safer sex, hostility, being accused of not trusting your partner, or no problems at all)
5. Do you feel that your partner listens to your concerns about pregnancy or STD's and takes you seriously?
6. Have you talked to your partner about AIDS? Does s/he agree that s/he should use a condom/dam every time or just sometimes?
7. Have you ever been coerced (or forced) into having unprotected sex? Or if you did have unprotected sex, was it your choice to do so?
8. Do you think you can say "no" to your partner without him/her leaving you or getting mad? What reaction do you get when you say "no"?
9. Do you feel it is your responsibility to protect yourself or do you depend on your partner for protection?
10. If he said you don't have to worry if you are on the pill because he doesn't have AIDS, would that make you feel safe?
11. What reasons would you give for not using a condom/dam when having sex? Why would you want to use a condom or dam?
12. Do you feel your friends use condoms/dams every time they have sex?
13. Have you talked to your friends about AIDS? Have you talked to your parents? Who would you most likely talk to if you had questions about AIDS?
14. Do you discuss with your partner(s) the kinds of sex/sexual practices you prefer? (such as oral rather than penetrative sex).

15. Do you feel that you get as much satisfaction from having sex with your partner as s/he does from you? Is your own pleasure/orgasm important to you?
16. Can you describe your most vivid memory of your first sexual encounter?
17. Do you have any other concerns or issues about HIV/AIDS in your sexual relationships that you would like to describe to me?
18. What is your idea of, or definition of "sex"? How might your definition differ from your partner's definition?
19. Overall, do you feel that safer sex is relevant to you in terms of your own sexual practices/activities? Why or why not?

APPENDIX C

THANK YOU FOR FILLING OUT THE QUESTIONNAIRE!

I would like to meet with you in person so we can talk more about AIDS and other sexuality issues. What you tell me in the interview will be kept confidential and no one will have access to your responses.

This will be your opportunity to discuss issues which I may not have included in this survey and which you may want me to know about. Anything you wish to tell me about these topics will be most appreciated.

Remember that whatever you tell me will be kept confidential.

Please leave your name and phone number on this page if you are willing to be interviewed. We will get together when and where it is best for you.

NAME: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

BEST TIME TO CALL YOU: \_\_\_\_\_

NOTE: By agreeing to leave your name and phone number, you have consented to an interview on HIV/AIDS-related issues which will take about 1 hour of your time.

THANK YOU FOR YOUR HELP!

Sincerely,

Jacquie Gahagan

M.A. Candidate  
Dept. of Sociology & Anthropology  
University of Windsor

969-6785

## VITA AUCTORIS

Jacqueline Gahagan was born in Drummondville, Quebec. She graduated from Carleton University with a B.A. in Anthropology and an Honours B.A. in Sociology. She is completing her M.A. in Sociology at The University of Windsor and hopes to graduate in June 1995. Jacqueline is currently a Ph.D. student at Wayne State University where she is studying Medical Sociology.